Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KIRT REPP DC
PO BOX 9973
THE WOODLANDS TX 77387

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-4819-01

MFDR Date Received
AUGUST 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As you may summize these are the exact sensory potentials that were recorded bilaterally addition to 10 units of 95904 (sensory NCV)."

Amount in Dispute: $480.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "See attached Medical Peer Review date 7/22/2010."

Response Submitted By: Caty Hineir

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2010	CPT Code 95904 (X4)	$120.00/each X 4= $480.00	$144.10

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, *33 Texas Register 3954*, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 15-150-Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 216-Based on findings of the review organization.

Issues

1. Does the documentation support billing of CPT code 95904?

Findings

1. The insurance carrier denied reimbursement for CPT code 95904 based upon reason code "150."

   On the disputed date of service the requestor billed for ten (10) units of CPT code 95904.

   The requestor noted in the Electrodiagnostic Evaluation /EMG-NCV report the following: "Sensory nerve conduction studies were within normal limits in the bilateral median, bilateral ulnar, left radial, left medial/lateral antebrachial cutaneous and right medial antebrachial cutaneous nerves." The requestor lists eight nerves tested, and was paid for six; therefore, additional reimbursement is due for the two additional nerve studies.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77029, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

   Using the above formula, the Division finds the MAR is $72.05. The requestor supports billing of additional two studies $72.05 X 2 = $144.10. As a result, additional reimbursement of $144.10 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $144.10.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $144.10 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		9/24/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.